Statewide Medicaid Managed Care Overview

June 2011

What Happens Before Implementation?

- As you may have read, the Legislation is effective July 1, 2011.
- Implementation will start by July 1, 2012 and will be complete by October 1, 2014.
- Between now and July 1, 2012, the Agency will work to implement the Statewide Medicaid Managed Care Program.
- Programs currently in existence will continue to operate as authorized by the Legislature. Any changes to these programs are unrelated to the Statewide Medicaid Managed Care Program.
- This presentation provides an overview of the implementation of the Statewide Medicaid Managed Care program.

The Federal Medicaid Program

- The changes that we are discussing today relate only to Medicaid and do not impact Medicare.
- Medicaid and Medicare are two distinct programs.
  - Medicare is a federal medical insurance program primarily for persons over 65.
  - Medicaid is a federal-state medical assistance program for low-income recipients of public benefit programs.
- Today we are only talking about the new Statewide Medicaid Managed Care Program, which is part of Florida Medicaid.

Statewide Medicaid Managed Care Background

- During the 2011 Florida Legislative Session, the House and Senate passed House Bill 7107 and HB 7109, which require the state Medicaid program to implement a Statewide Medicaid Managed Care Program.
- The legislation expands and improves Florida's managed care programs.
- Today the state contracts with 25 Medicaid Managed Care plans.
  - 19 Health Maintenance Organizations (HMOs)
  - 6 Provider Service Networks (PSNs)
- Currently over 1.3 million recipients are enrolled in a managed care plan (HMO, PSN, Nursing Home Diversion).

The Evolution of Florida Medicaid Delivery Systems

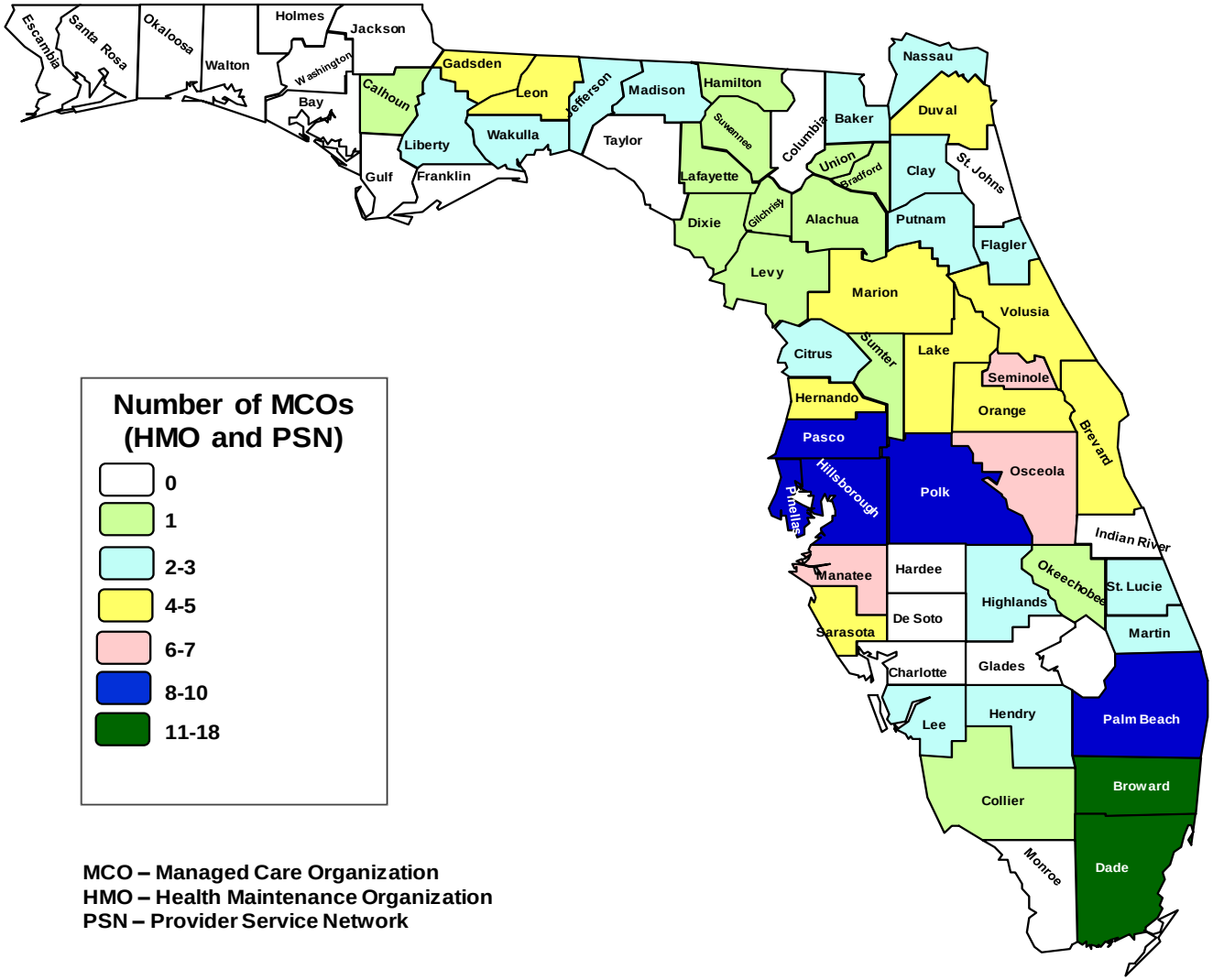
1970 - 1983 → **Fee-for-Service**

1984 - 1997 →
HMOs – Since 1984
MediPass (PCCM) – Since 1991

1997 -2003 →
Provider Service Network - Since 2000
Disease Management
Long Term Care Management
Other Alternative Plans - Since 2001

2004 - Present →
Integrated Care Management/Care Coordination
Quality Assurance
Fraud and Abuse Controls
New:
- **Medicaid Reform Specialty Plans**
- **Medicaid Encounter Data**
- **Capitated PSNs–Since 2008**

Managed Care in Florida Medicaid by County as of April 1, 2011



MCO – Managed Care Organization
HMO – Health Maintenance Organization
PSN – Provider Service Network

Overview of 2011 Legislation

- During the 2011 Florida Legislative Session, the House and Senate passed HB 7107 and HB 7109, which require the state Medicaid program to implement a Statewide Medicaid Managed Care Program.
- The Statewide Medicaid Managed Care Program is to have two key program components:
  - the Long Term Care Managed Care Program
  - the Managed Medical Assistance Program
- All Medicaid recipients are required to enroll in a managed care plan unless specifically exempted in the legislation.
- Certain recipients are eligible for and required to enroll in the Long Term Care Managed Care Program of the Statewide Medicaid Managed Care Program.

Why Change the Program?

- House Bill 7107 requires the Agency to implement a Statewide Medicaid Managed Care Program. The goals are:
  - improved coordination of care
  - a system that focuses on improving the health of beneficiaries, not just paying claims when people are sick
  - enhanced accountability
  - recipient choice of plans and benefit packages
  - flexibility to offer services not otherwise covered
  - enhanced fraud and abuse prevention through contract requirements.

Other Key Legislative Provisions

- Some other key provisions of the legislation include:
  - changes to the Medically Needy Program relating to plan enrollment and premium requirements
  - changes to the Developmental Disabilities program relating to premium requirements for families of certain enrollees
  - opt-out and premium assistance program for eligibles with access to other insurance
  - increased copayments for nonemergency use of the emergency room.
- Federal authority is needed to implement key provisions.

The Statewide Medicaid Managed Care Program does not/is not:

- The Statewide Medicaid Managed Care Program ***does not*** limit medically necessary services.
- The Statewide Medicaid Managed Care Program ***is not*** linked to changes in the Medicare program and does not change Medicare benefits or choices.
- The Statewide Medicaid Managed Care Program ***is not*** linked to National Health Care Reform, or the Affordable Care Act, passed by the U.S. Congress.
  - It does not contain mandates for individuals to purchase insurance.
  - It does not contain mandates for employers to purchase insurance.
  - It does not expand Medicaid coverage or cost the state or federal government any additional money.

When will changes occur?

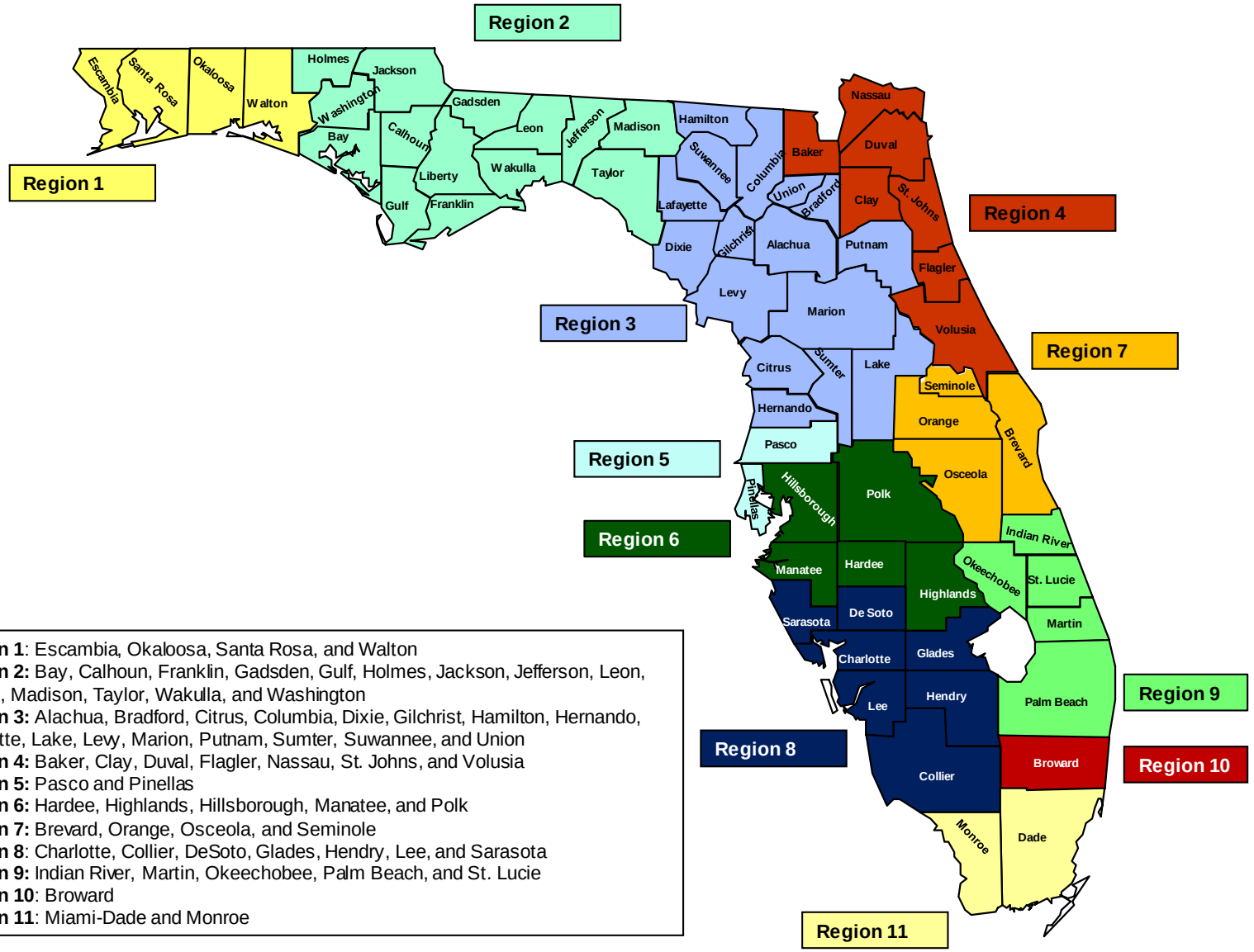
HB 7107 provides timelines for implementation of both the Long Term Care Managed Care Program and the Managed Medical Assistance Program.

- Federal authority is needed to implement key provisions.
- The Agency is required to submit any necessary waiver or state plan amendment request by August 1, 2011.
- Full program implementation of the Statewide Medicaid Managed Care Program must be completed by October 1, 2014.
  - The Agency must begin implementation of the Long Term Care Managed Care component by July 1, 2012 and have the component fully implemented by October 1, 2013.
  - The Agency must begin implementation of the Managed Medical Assistance component by January 1, 2013 and have the component fully implemented by October 1, 2014.

Where will the program be implemented statewide?

- HB 7107 establishes 11 regions in the state.
  - These regions align with the 11 existing Medicaid regions.
- The Agency is required to separately procure for Long Term Care Managed Care plans and Managed Medical Assistance plans in each of the 11 regions.
- The Agency is required to select a limited number of eligible plans to participate in the Statewide Medicaid Managed Care Program using invitations to negotiate.
- Each recipient shall have a choice of plans and may select any available plan unless that plan is restricted by contract to a specific population that does not include the recipient.

Statewide Medicaid Managed Care Regions Map



Region 1: Escambia, Okaloosa, Santa Rosa, and Walton
Region 2: Bay, Calhoun, Franklin, Gadsden, Gulf, Holmes, Jackson, Jefferson, Leon, Liberty, Madison, Taylor, Wakulla, and Washington
Region 3: Alachua, Bradford, Citrus, Columbia, Dixie, Gilchrist, Hamilton, Hernando, Lafayette, Lake, Levy, Marion, Putnam, Sumter, Suwannee, and Union
Region 4: Baker, Clay, Duval, Flagler, Nassau, St. Johns, and Volusia
Region 5: Pasco and Pinellas
Region 6: Hardee, Highlands, Hillsborough, Manatee, and Polk
Region 7: Brevard, Orange, Osceola, and Seminole
Region 8: Charlotte, Collier, DeSoto, Glades, Hendry, Lee, and Sarasota
Region 9: Indian River, Martin, Okeechobee, Palm Beach, and St. Lucie
Region 10: Broward
Region 11: Miami-Dade and Monroe

Who will participate in the Statewide Medicaid Managed Care Program?

- All Medicaid recipients will be enrolled in a managed care plan unless specifically exempted.
- Recipients required to enroll in either a Managed Medical Assistance plan or a Long Term Care plan will include, but are not limited to:
  - Temporary Assistance for Needy Families (TANF) and TANF related
  - Children with chronic conditions, including foster care children
  - Pregnant women
  - Medically Needy recipients
  - Individuals with Medicare coverage (Medicaid acts as a secondary payer)
  - Persons eligible for Medicaid by reason of a disability, excluding the Developmentally Disabled (DD) population
  - Persons determined by the Comprehensive Assessment Review and Evaluation for Long-Term Care Services (CARES) Program to require nursing facility care as defined in s. 409.985(3), F.S., for whom sufficient funding is available.

Who may participate in the Statewide Medicaid Managed Care Program?

- Certain Medicaid recipients may voluntarily participate in the program, but are not required to enroll. The recipient who may participate include:
  - Medicaid recipients who have other creditable health care coverage, excluding Medicare
  - Medicaid recipients residing in residential commitment facilities operated through the Department of Juvenile Justice or mental health treatment facilities as defined by section 394.455(32), F.S.
  - persons eligible for refugee assistance
  - Medicaid recipients who are residents of a developmental disability center, including Sunland Center in Marianna and Tacachale in Gainesville
  - Medicaid recipients enrolled in the home and community based services waiver pursuant to chapter 393 (developmental disability waivers), and Medicaid recipients waiting for waiver services.

Who will not participate in Statewide Medicaid Managed Care Program?

- HB 7107 provides certain Medicaid recipients will not participate in the Statewide Medicaid Managed Care Program, including:
  - women who are eligible only for family planning services
  - women who are eligible only for breast and cervical cancer services
  - persons who are eligible for emergency Medicaid for aliens
  - children receiving services in a prescribed pediatric extended care center.

Which health plans can participate?

- All of these types of health plans are eligible to participate:
  - Health Maintenance Organizations
  - Provider Service Networks
  - Accountable Care Organizations
  - Exclusive Provider Organizations
  - Medicare Advantage Plans that exclusively service Medicaid recipients
  - Program of All-Inclusive Care for the Elderly
  - Children's Medical Services Network

What to expect

- Posting of waiver request and approval documents to Agency's website.
- Release of procurement documents no later than July 1, 2012, for Long Term Care and no later than January 1, 2013, for Managed Medical Assistance.
- Ongoing opportunity for public comment – via e-mail or letter.
- Notification to recipients of available plans once readiness review of selected plans is completed.
- Notification to recipients of timeline for plan choice.

Timeline of recipient plan choice

- Once plans are selected, an outreach schedule will be developed and the Agency will inform individuals about their choices.
- Recipients will have 30 days to select a plan.
  - If no plan is selected, the Agency will assign the recipient to a plan.
- Recipients will have 90 days after plan enrollment to disenroll and select another plan.
- Recipients can change plans at other times if good cause (as defined in HB 7107) exists.

Public input and program improvements

- Florida Medicaid is open to feedback from any stakeholder, including recipients, providers, advocates and researchers.
- Based on feedback, Florida Medicaid has taken advantage of opportunities to adapt and improve and will continue to do so.
- Recommendations and suggestions regarding the program will be considered in response to public input, as appropriate.
- If the Agency receives comments that would require legislative action, we will review and make them available to the Legislature.

How to find information about program changes

- Today's presentation is posted on the Agency website.
- The Agency website will include information about:
  - the status of the waiver to federal CMS
  - the implementation timeline
  - the progress of the negotiation and contracting with plans
  - information for providers and recipients about implementation and plan enrollment as it becomes available.
- Go to www.ahca.myflorida.com and click 

on the left, below the picture of the Secretary.
  - Sign up to receive e-mail updates via the website.

Ways to submit comments

- Fill out and submit the comment form provided at the sign-in table.
- Email your comments and suggestions to FLMedicaidManagedCare@AHCA.myflorida.com.
- Submit comments by mail to:

  Statewide Medicaid Managed Care Program
  Office of the Deputy Secretary for Medicaid
  Agency for Health Care Administration
  2727 Mahan Drive, MS #8
  Tallahassee, FL 32308

Begin Public Comment Period

Supplemental Information: Medicaid Overview

The Federal Medicaid Program

- Federal Medicaid laws and regulations mandate certain benefits for certain populations and states must administer their programs under federally approved state plans.

- To participate, states are required to cover certain mandatory populations and services, while federal matching funds are available if a state chooses to cover other optional populations and services.

The Federal Medicaid Program

- States must submit a Medicaid State Plan to the federal Centers for Medicare and Medicaid Services (CMS) and administer their programs under federally approved state plans.
- The Plan outlines current Medicaid eligibility standards, policies and reimbursement methodologies to ensure the State program receives matching federal funds under Title XIX of the Social Security Act.
- Services must be available statewide in the same amount, duration and scope.
  - cannot choose to provide a service in only one geographic area;
  - cannot have a higher service limit for a certain group of recipients (with the exception of children)

The Florida Medicaid Program

- There are approximately 110,000 Florida Medicaid enrolled individual providers and facilities offering health care services as well as 25 Medicaid Managed Care plans.
  - 19 Health Maintenance Organizations (HMOs)
  - 6 Provider Service Networks (PSNs).

- Medicaid's contracted Fiscal Agent processes approximately 135 million claim lines every year.

The Florida Medicaid Program

- Florida is the fifth largest state in terms of Medicaid expenditures, with estimated spending of nearly $20 billion for fiscal year 2010-2011 (July 2010 through June 2011).

- More than 3 million Floridians are enrolled in the Florida Medicaid program. They are elders, disabled people, families, pregnant women and children in low-income families.

- Florida has the fourth largest Medicaid population in the country.

Florida Medicaid Mandatory Services

- Advanced Registered Nurse Practitioner Services
- Early & Periodic Screening, Diagnosis and Treatment of Children (EPSDT)/Child Health Check-Up
- Family Planning
- Home Health Care
- Hospital Inpatient
- Hospital Outpatient
- Independent Lab
- Nursing Facility
- Personal Care Services
- Physician Services
- Portable X-ray Services
- Private Duty Nursing
- Respiratory, Speech, Occupational Therapy
- Rural Health
- Therapeutic Services for Children
- Transportation

*Florida Medicaid Optional Services**

- Adult Dental Services
- Adult Health Screening
- Ambulatory Surgical Centers
- Assistive Care Services
- Birth Center Services
- Hearing Services
- Vision Services
- Chiropractic Services
- Community Mental Health
- County Health Department Clinic Services
- Dialysis Facility Services
- Durable Medical Equipment
- Early Intervention Services
- Healthy Start Services
- Home and Community-Based Services
- Hospice Care
- Intermediate Care Facilities/ Developmentally Disabled
- Intermediate Nursing Home Care
- Optometric Services
- Physician Assistant Services
- Podiatry Services
- Prescribed Drugs
- Primary Care Case Management (MediPass)
- Registered Nurse First Assistant Services
- School-Based Services
- State Mental Hospital Services
- Subacute Inpatient Psychiatric Program for Children
- Targeted Case Management)

*States are required to provide any medically necessary care required by child eligibles.

Medicaid Waivers

- In order for states to implement programs that deviate from their state plan (to vary by geographic areas, amount, duration and scope), the state must request a waiver.

- A waiver is a program requested by a state and approved by the Centers for Medicare and Medicaid Services (CMS) that waives certain provisions of the Social Security Act.

- Waiver types:
  - 1915(b)
  - 1915(c)
  - 1115

1915(b) Waivers

- Freedom of Choice

  Purpose: Allow state Medicaid programs to waive the requirement that "any willing qualified provider" can enroll and provide Medicaid reimbursable services. This allows the state to elect a limited number of providers to serve recipients and is often done to improve continuity of care and ensure cost-savings.

  Federal Provisions waived: Any section of 1902 of the Social Security Act depending on the design of the waiver request. A waiver request can include any or all of these components:

  1915(b)(1): Managed Care

  1915(b)(2): Choice counseling for managed care plans

  1915(b)(3): Additional services from cost savings

  1915(b)(4): Require beneficiaries to use specified providers

1915(c) Waivers

- Home and Community Based Services
  - Purpose: Allow state Medicaid programs to cover services traditionally viewed as "long-term care" and provide them in a community setting to individuals instead of nursing home or Intermediate Care Facility for the Developmentally Disabled (ICF/DD).
  - Federal Provisions waived:
    - Comparability: 1915(c) waiver services may be limited to a targeted group of individuals (e.g., elderly or disabled adults)
    - State-wideness: 1915(c) waiver services may be limited to particular geographic areas (e.g., county, region)

1115 Waivers

- Research and demonstration waivers
  - Purpose: To test or pilot a unique program or method of service delivery. These waivers are often academic in nature and often require comprehensive evaluations of effectiveness.
  - Federal provisions waived: Any section of 1902 and 1905 of the Social Security Act depending on the design of the waiver request.

Florida Medicaid's Current Waivers

- 1915(b)
  - Non-Emergency Transportation
  - Medicaid Managed Care
- 1915(c)
  - 15 specialized home and community based services waivers
- 1115
  - Family Planning
  - Meds-AD (1115)
  - Medicaid Reform

Florida Medicaid Enrollment Today

(April 1, 2011)

Delivery System	Number of Plans	Number of Counties	Statewide Enrollment
Health Maintenance Organization (Non-Reform)	17	38	975,054
Health Maintenance Organization (Reform)	9	5	154,511
FFS Provider Service Network	4	6	139,105
Capitated Provider Service Network	2	30	67,096
Nursing Home Diversion	16	40	17,927
Fee-For-Service	N/A	67	924,497
MediPass	N/A	67	616,233

Florida Medicaid Enrollment Today

(April 1, 2011)

Delivery System	Statewide Enrollment
Health Maintenance Organization (Non-Reform)	975,054
Health Maintenance Organization (Reform)	154,511
Capitated Provider Service Network	67,096
FFS Provider Service Network	139,105
Nursing Home Diversion	17,927
Total Managed Care Enrollment	**1,353,693**

Delivery System	Statewide Enrollment
Fee-For-Service	924,497
MediPass	616,233
Total Fee-For-Service Enrollment	**1,540,730**

Supplemental Information: Additional Information about the Long Term Care Managed Care Component

Statewide Medicaid Managed Care Program
Long Term Care Managed Care: Timelines

- The Long Term Care Managed Care component of the Statewide Medicaid Managed Care program will be implemented first.

- HB 7107 sets specific timelines for implementation of the Long Term Care Managed Care Program.
  - The Agency must begin implementation by July 1, 2012.
  - The Agency must complete implementation in all regions by October 1, 2013.

Statewide Medicaid Managed Care Program
Long Term Care Managed Care: Procurement Process

- The Agency must competitively procure plans to serve the Long Term Care Managed Care population.

- The Agency is required to conduct simultaneous procurements for Long Term Care plans in each of the 11 regions.

Statewide Medicaid Managed Care Program
Long Term Care Managed Care: Plans per area

- The Agency is required to select a limited number of eligible plans to participate in the Long Term Care Managed Care component using invitations to negotiate: a minimum of 30, maximum of 53 and at least one PSN in each Region.

	Min # of Plans	Max # of Plans	# of PSNs
Region 1	2	2	1
Region 2	2	2	1
Region 3	3	5	1
Region 4	3	5	1
Region 5	2	4	1
Region 6	4	7	1
Region 7	3	6	1
Region 8	2	4	1
Region 9	2	4	1
Region 10	2	4	1
Region 11	5	10	1
Total	30	53	11

Statewide Medicaid Managed Care Program
Long Term Care Managed Care: ITN Procurement

- The Agency anticipates release of the procurement no later than July 1, 2012.

- The Agency will develop roll out schedule for enrollment into plans based on, but not limited to, the following:
  - plan readiness
  - utilization patterns
  - number of eligible recipients

Statewide Medicaid Managed Care Program
Long Term Care Managed Care: Participating Plans

- Eligible plans include:
  - Health Maintenance Organizations
  - Provider Services Networks
  - Exclusive provider organizations
  - Accountable care organizations
  - Medicare Advantage Preferred Provider Organizations
  - Medicare Advantage Provider-sponsored Organizations
  - Medicare Advantage Special Needs Plans
  - Program of All-Inclusive Care for the Elderly.

Statewide Medicaid Managed Care Program
Long Term Care Managed Care: Covered Services

Minimum Required Covered Services: Long Term Care Managed Care Plans	
Behavior management	Medication management
Caregiver Training	Nursing Facility Care
Case management	Nutritional Assessment and risk reduction
Home accessibility adaptation	Personal Care
Home delivered meals	Personal emergency response system
Hospice	Respite Care
Intermittent and skilled nursing	Services provided in assisted living facilities
Medical requirement and supplies, including incontinence supplies	Therapies (Occupational, Speech, Respiratory, Physical)
Medication administration	Transportation

Who will participate in Long Term Care Managed Care Program?

- Medicaid recipients who meet all of the following criteria are eligible to receive long-term care services and must receive long-term care services by participating in the long-term care managed care program.
- The recipient must be:
  - (a) 65 years of age or older, or age 18 or older and eligible for Medicaid by reason of a disability.
  - (b) Determined by the Comprehensive Assessment Review and Evaluation for Long-Term Care Services (CARES) Program to require nursing facility care as defined in s. 409.985(3).

Who will participate in Long Term Care Managed Care Program?

- Medicaid recipients who, on the date long-term care managed care plans become available in their region, reside in a nursing home facility or are enrolled in one of the following long-term care Medicaid waiver programs are eligible to participate in the long-term care managed care program.

Program	Enrollment April 2011
Assisted Living for the Elderly	3,143
Aged/ Disabled Adult	10,017
Adult Day Health Care	22
Consumer-Directed Care Plus Program	2,076
PACE	527
Nursing Home Diversion	17,927
Channeling	1,291

Who Will Not Participate in Long Term Care Managed Care Program?

- HB 7107 does not expand enrollment to include those currently on home and community based services wait lists.
  - HB 7107 provides that the Department of Elder Affairs will make offers for enrollment to eligible individuals based on a wait-list prioritization and subject to availability of funds.
  - The Department of Elder Affairs is required to determine that sufficient funds exist before making offers of enrollment.

Supplemental Information: Additional Information about the Managed Medical Assistance Component

Statewide Medicaid Managed Care Program
Managed Medical Assistance Program: Timelines

- The Managed Medical Assistance component of the Statewide Medicaid Managed Care program will be implemented second.

- HB 7107 sets specific timelines for implementation of the Managed Medical Assistance Program.
  - The Agency must begin implementation by January 1, 2013.
  - The Agency must complete implementation in all regions by October 1, 2014.

Statewide Medicaid Managed Care Program Managed Medical Assistance Program: Procurement Process

- The Agency must competitively procure plans to serve the Managed Medical Assistance Program population.
- The Agency is required to conduct simultaneous procurements for Long Term Care plans in each of the 11 regions.
- Long Term Care Managed Care plans can elect to submit bids to become Comprehensive Long Term Care Plans which provide both Managed Medical Assistance and Long Term Care Services.

Statewide Medicaid Managed Care Program
Managed Medical Assistance Program: Plans per Region

- The Agency is required to select a limited number of eligible plans to participate in the Managed Medical Assistance program using invitations to negotiate: a minimum of 30, maximum of 53 and at least one PSN in each Region.

	Min # of Plans	Max # of Plans	# of PSNs
Region 1	2	2	1
Region 2	2	2	1
Region 3	3	5	1
Region 4	3	5	1
Region 5	2	4	1
Region 6	4	7	1
Region 7	3	6	1
Region 8	2	4	1
Region 9	2	4	1
Region 10	2	4	1
Region 11	5	10	1
Total	30	53	11

Statewide Medicaid Managed Care Program Managed Medical Assistance Program: Timelines

- The Agency anticipates release of the procurement no later than July 1, 2012.

- The Agency will develop roll out schedule for enrollment into plans based on, but not limited to, the following:
  - plan readiness
  - utilization patterns
  - number of eligible recipients

Statewide Medicaid Managed Care Program
Managed Medical Assistance Program: Eligible Plans

- Eligible plans include:
  - Health Maintenance Organizations
  - Provider Services Networks
  - Exclusive provider organizations
  - Accountable care organizations
  - Children's Medical Services Network
  - Specialty Plans (serving a specific target population based on age, chronic disease state, or medical condition of the enrollee)

Statewide Medicaid Managed Care Program Managed Medical Assistance Program: Covered Services

Minimum Required Covered Services: Managed Medical Assistance Plans	
Advanced registered nurse practitioner services.	Medical supply, equipment, prostheses and orthoses
Ambulatory surgical treatment center services	Mental health services
Birthing center services	Nursing care
Chiropractic services	Optical services and supplies
Dental services	Optometrist services
Early periodic screening diagnosis and treatment services for recipients under age 21	Physical, occupational, respiratory, and speech therapy
Emergency services	Physician services, including physician assistant services
Family planning services and supplies (some exception)	Podiatric services
Healthy Start Services (some exception)	Prescription drugs
Hearing services	Renal dialysis services
Home health agency services	Respiratory equipment and supplies
Hospice services	Rural health clinic services
Hospital inpatient services	Substance abuse treatment services
Hospital outpatient services	Transportation to access covered services
Laboratory and imaging services	

Statewide Medicaid Managed Care Program Managed Medical Assistance Program: Covered Services

- Managed Medical Assistance plans are authorized to customize their benefits packages to non-pregnant adults, vary cost sharing provisions, and provide coverage for additional services.
  - The Agency is required to evaluate the proposed benefit package to ensure that services are sufficient to meet the needs of the plans' enrollees and to verify actuarial equivalence.
- Certain services are excluded from the plan benefit packages and are "carved out" to remain under the fee-for-service system.
  - Services provided in a prescribed pediatric extended care facility.
  - Provision of anti-hemophilic factor replacement products to recipients diagnosed with hemophilia through the Agency's hemophilia disease management program.

Who will participate in the Managed Medical Assistance Program?

- All Medicaid recipients will be enrolled in a managed care plan unless specifically exempted.
- Recipients required to enroll in either a Managed Medical Assistance plan or a Long Term Care plan will include, but are not limited to:
  - Temporary Assistance for Needy Families (TANF) and TANF related
  - Children with chronic conditions, including foster care children
  - Pregnant women
  - Medically Needy recipients
  - Individuals with Medicare coverage (Medicaid acts as a secondary payer)
  - Persons eligible for Medicaid by reason of a disability, excluding the Developmentally Disabled (DD) population
  - Persons determined by the Comprehensive Assessment Review and Evaluation for Long-Term Care Services (CARES) Program to require nursing facility care as defined in s. 409.985(3), F.S., for whom sufficient funding is available.

Who may participate in the Manage Medical Assistance Program?

- Recipients who may choose to enroll in a Managed Medical Assistance Program (but we are not required to enroll) include:
  - Medicaid recipients who have other creditable health care coverage, excluding Medicare
  - Medicaid recipients residing in residential commitment facilities operated through the Department of Juvenile Justice or mental health treatment facilities as defined by section 394.455(32), F.S.
  - Persons eligible for refugee assistance
  - Medicaid recipients who are residents of a developmental disability center, including Sunland Center in Marianna and Tacachale in Gainesville
  - Medicaid recipients enrolled in the home and community based services waiver pursuant to chapter 393, and Medicaid recipients waiting for waiver services.

Who will not participate in Manage Medical Assistance Program??

- Recipients who are excluded from the Managed Medical Assistance Program and who will not participate include:
  - women who are eligible only for family planning services
  - women who are eligible only for breast and cervical cancer services
  - persons who are eligible for emergency Medicaid for aliens
  - children receiving services in a prescribed pediatric extended care center.

Supplemental Information: Additional Information about Plan Requirements and Other Program Components

Statewide Managed Care Program Additional Requirements for Health Plans

- Guaranteed savings:
  - The Agency is required to negotiate capitation rates or FFS payments with each plan to guarantee aggregate savings of at least 5% for the first contract year.
- Achieved savings rebate:
  - HB 7107 establishes a program through which a percentage of savings achieved by health plans is retained by the plan and a percentage of savings achieved is returned to the state.
  - The Agency is responsible for verifying achieved savings through compliance audits on plan financial reports conducted by an independent certified public accountant. Plans are responsible for the costs of the audits.

Statewide Managed Care Program Additional Requirements for Health Plans

- Fraud and abuse requirements
- HB 7107 includes new requirements for plans. As part of these requirements, plans must:
  - have an effective prepayment and postpayment review process including data analysis, system editing and auditing of network providers,
  - have in place procedures for reporting instances of fraud and abuse,
  - have administrative and management arrangements or procedures, including a mandatory compliance plan, designed to prevent fraud and abuse.

Statewide Managed Care Program Additional Requirements for Health Plans

- HB 7107 and HB 7109 specify analysis and utilization of encounter data.
  - The Agency will develop protocols for ongoing analysis of the encounter data that adjusts for differences in characteristics of prepaid plan enrollees to allow comparison of service utilization among plans and against expected levels of use.
  - The Agency will use this analysis to identify possible cases of systemic underutilization or denials of claims and inappropriate service utilization such as higher-than-expected emergency department encounters.
  - The Agency will provide periodic feedback to the plans and enable the Agency to establish corrective action plans when necessary.

Statewide Managed Care Program
Additional Requirements for Health Plans

- Penalties for plan withdrawal:
  - Managed care plans that reduce enrollment levels or leave a region before the end of the contract term must reimburse the Agency for the cost of enrollment changes and other transition activities.
    - If a plan leaves a region before the end of the contract term, the Agency will terminate all contracts with that plan in other regions.

Statewide Managed Care Program Additional Requirements for Health Plans

- Penalties for failure to submit encounter data:
  - Managed care plans that fail to comply with encounter data reporting will be assessed a fine of $5,000 per day for each day of noncompliance beginning on the day 31.
    - Contract termination on day 90 if not in compliance.
    - Termination of all regional contracts held by the plan if the Agency terminates more than one regional contract due to noncompliance with encounter data requirements.

Statewide Medicaid Managed Care Program
Other Program Components

- Long Term Care Technical Advisory Workgroup:
  - Establish workgroup by August 1, 2011.
  - The authority for the workgroup expires June 30, 2013.
  - Assist the Agency in developing the following:
    - method of determining Medicaid eligibility
    - requirements for provider payments to nursing homes
    - method for managing Medicare coinsurance crossover claims
    - requirements for claims submissions and payments, including electronic funds transfers and claims processing.
- The workgroup will include representatives of providers and plans who could potentially participate in long term care managed care.

Statewide Medicaid Managed Care Program
Other Program Components

- Access to care partnership:
  - The Agency is to contract with an administrative services organization that has operating agreements with all health care facilities, programs, and providers supported with local taxes or certified public expenditures.
  - To provide for enhanced access to care for Medicaid, low-income, and uninsured Floridians. Under the contract, the Access to Care Partnership will be responsible for an ongoing program of activities that provide needed, but uncovered or undercompensated, health services to Medicaid enrollees and persons receiving charity care.

Statewide Medicaid Managed Care Program
Other Program Components

- Florida Medical Schools Quality Network:
  - The Agency is to contract with a single organization representing medical schools and graduate medical education programs in the state for the purpose of establishing an active and ongoing program to improve clinical outcomes in all managed care plans.
  - Contracted activities must support greater clinical integration for Medicaid enrollees through interdependent and cooperative efforts of all providers participating in managed care plans.
  - Activities are to be supported with certified public expenditures and any earned federal matching funds.
  - Plans must contract with each managed care network in order to participate in the quality network.

Statewide Medicaid Managed Care Program
Other Program Components

- Health Start Coalition Administrative Services Organization:
  - The Agency is to contract with an administrative services organization representing all Healthy Start Coalitions.
  - Requires the network (called the MomCare Network) of coalitions to provide counseling, education, risk-reduction and case management services, and quality assurance for all enrollees of the waiver.
  - The Agency is required to evaluate the impact of the MomCare network by monitoring each plan's performance on specific measures to determine the adequacy, timeliness, and quality of services for pregnant women and infants.
  - Activities of the network are to be supported by certified public expenditures of general revenue appropriated for Healthy Start services and any earned federal matching funds.

Statewide Medicaid Managed Care Program
Other Program Components

- Changes to the Medically Needy Program (HB 7107):
  - HB 7107 creates section 409.972, Florida Statues, which outlines populations that are mandatory and voluntary for enrollment.
  - Section 409.972, F.S., specifically states that persons eligible for the program known as "medically needy" pursuant to section 409.904(2)(a), F.S., shall enroll in managed care plans.
  - Under section 409.972, F.S., medically needy recipients meet the share of the cost by paying the plan premium, up to the share of the cost amount, contingent upon federal approval.

Statewide Medicaid Managed Care Program
Other Program Components

- Changes to the Medically Needy Program (HB 7109):
  - The Agency is to contract with provider service network to function as a third-party administrator and managing entity for the Medically Needy program in all counties.
  - The contractor is required to provide care coordination and utilization management.
  - The contractor is to collect a monthly premium from each Medically Needy recipient provided the premium does not exceed the enrollee's share of cost as determined by the Department of Children and Families.
  - This authority expires October 1, 2014, or upon full implementation of the managed medical assistance program, whichever is sooner.

Statewide Medicaid Managed Care Program
Other Program Components

- Cost Sharing:
  - HB 7107 directs the Agency to implement a requirement that Medicaid recipients enrolled in managed care plans, as a condition of Medicaid eligibility, pay the Medicaid program a share of the premium of $10 per month.
- Cost Sharing
  - HB 7109 directs the Agency to implement a requirement for payment of a $100 copayment for non-emergency services and care furnished in a hospital emergency department.
  - HB 7109 directs the Agency to request federal authority to require the payment of premiums or other cost sharing by the parents of a child who assess a fee (based on a sliding scale) against the parents of a child who is being served by a developmental disabilities waiver if the adjusted household income is greater than 100 percent of the federal poverty level.

Statewide Medicaid Managed Care Program
Other Program Components

- Opt Out and Premium Assistance Programs:
  - HB 7107 and HB 7109 require the Agency to develop a process to enable a recipient with access to employer-sponsored health care coverage to opt out of all managed care plans and to use Medicaid financial assistance to pay for the recipient's share of the cost in such employer-sponsored coverage.
  - The amount of financial assistance provided for each recipient may not exceed the amount of the Medicaid premium that would have been paid to a managed care plan for that recipient.